Executive Summary
King/Drew Medical Center Workplan Implementation
March 11, 2005

Governance

A governing body for King/Drew Medical Center (KDMC), Hospital Advisory Board (HAB) has been approved by the Los Angeles County Board of Supervisors (BOS). The BOS will remain the official governing body for KDMC for all purposes, including compliance with federal Medicare regulations, Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) standards, and state licensing rules. BOS will retain ultimate authority for the quality of care and the operation of KDMC. However, to the extent possible, BOS will delegate responsibilities to HAB, with the goal that HAB provide policy-level direction and oversight to KDMC. In some cases, HAB will be given final decision making authority, in all other circumstances, HAB will make recommendations which will be presented to BOS or the Director of the Los Angeles County Department of Health Services (DHS) for consideration. HAB membership is in the process of being approved by the BOS from recommendations provided by Navigant Consulting.

Leadership/Management

Revised organizational charts have been implemented for the Chief Executive Officer, Medical Director, Chief Nursing Officer and Chief Operating Officer.

Recruitment is being initiated in March on all interim executive/management positions. Functional job descriptions have been revised for Executive and Senior Managers. Goals and objectives have been identified for each. There is ongoing assessment of current KDMC leadership capabilities against the functional job descriptions.

Communication

Public relations has moved from an ad-hoc process to a formalized functioning office. A DHS Communication employee has been identified and is now serving half time at KDMC to assist with management of the flow of public information, provide advice to hospital leadership on public relations issues, and assist with crafting key internal and external messaging. This month a redesigned employee newsletter was launched to keep all KDMC employees apprised of administration and regulatory updates, campus events, HR initiatives and other news items. Planning is in process to publish a specialized physician newsletter each month for Medical Administration. As part of the short-term communications plan, KDMC Public Relations will begin hosting informal employee lunch meetings this month with leadership from key departments to facilitate information flow providing an opportunity to showcase department milestones and build internal support around the organizational change. Last month COO, Linda McAuley, and Advisor to the Laboratory, Josue Rodas, were featured guests on a well-known local public affairs program reaching an important Hispanic audience. We have generated positive placement with KNBC, KPCC, KNX, KFWB and La Opinion, among other print and broadcast outlets. We are working with PBS affiliate KCET for an in-depth look at the organizational change to air as early as May. We are also working with NPR on an upcoming segment.

Regulatory/Performance Improvement and Quality

The Plan of Correction for management of assaultive behavior has been accepted by the Centers for Medicare and Medicaid Services (CMS) and in a recent CMS survey the hospital was successful in having an Immediate Jeopardy and Notice of Termination rescinded. Action plans have been developed for all 288 deficiencies/citations related to Joint Commission standards, Residency Review Committee (RRC)/Graduate Medical Education Committee (GMEC), CMS Conditions of Participation and Title 22 regulations. Specific accountability by individual manager has been identified and communicated to all managers to provide clarity on what their individual role is to restore Accreditation. A mock survey program will begin this month to ensure that implemented improvements have been sustained. There are a total of 353 issues addressed in the regulatory action plan including 65 RRC/GMEC citations. Of these 353 issues, 304 (86%) are cross-walked to recommendations in the KDMC Implementation Plan recommendations for which status will be reported in the

bi-weekly updates. There are 49 non-cross walked issues that need more specific plans of action and separate status updates.

The critical/sentinel event notification process is being overhauled to ensure that all staff understand and report events; issues are addressed within 24 hours; and a multidisciplinary route cause analysis is completed in a timely manner.

The charter for a Quality Oversight Committee has been developed as a subcommittee of the newly formed independent Hospital Advisory Board. The purpose of this committee is to oversee, assess, review and revise all organizational performance improvement and quality initiatives that relate to the goal of quality patient care and patient safety throughout KDMC.

The Infection Control Committee has reviewed and approved the new Infection Control plan. Revisions have been made to the data collection process to produce meaningful analysis of performance of the infection control process.

Clinical Organization

Active planning is in process for a palliative care/end of life program. A new skin program has been developed and is to be implemented this month. A design session is being planned to redesign all patient documentation to ensure it is clinician friendly and meets all regulatory requirements. There is a new nurse recruiter in place, although minimal progress has been made to reduce percentages of agency staff.

The Trauma Center closed March 1 with few issues. The Emergency Department (ED) diversion policy was revised identifying specific criteria for diversion; reducing the interval allowed for diversion from four to two hours and requiring communication and approval to go on diversion. February diversion decreased by approximately 30% compared to January (528 hours/January to 367 hours/February). Interdisciplinary patient protocols have been developed to improve patient movement through the ED from initial presentation to inpatient transfer or discharge. The ED Joint Practice Group has been formed and is beginning its efforts to oversee clinical practice in the ED.

In psychiatry a new treatment model for Psychiatric Emergency Services (PES) was implemented. Weekly focus group meetings have been instituted to discuss and revise the patient treatment model. Seven-day/week coverage for occupational therapy, recreational therapy and social workers was instituted for

all units, including PES. The therapeutic milieu has been improved with consistent staff coverage on each unit and PES. Improved programming has begun with therapeutic groups being run by all disciplines. Daily rounds have been instituted on all units and PES to review the care plan. A quality improvement plan has been developed with indicators to be monitored by each specific discipline and reported to the Psychiatric Management Team.

The OR Governance Committee has been reconfigured with new membership with the first meeting scheduled for March 30th. A redesign of function and patient flows of the Outpatient Surgery Assessment (OSA) is planned for March. Working with the HMC architect on renovations to improve the perioperative environment are in the final stages of design and timeline composition with architects. Alternative location to support consolidated volume is underway. Daily throughput improved through aggressive PAR discharge planning and proactive bed assignment prior to surgery. Utilization has remained at 24% with six staffed ORs. Actions to revise current hours of operation and/or close hours will be balanced with renovation plans.

Medical Administration/Care Management/Capacity and Patient Throughput

Medical Admin staff has been reconfigured to include Associate Medical Director (AMD) position for Med Staff Affairs and Utilization Management (UM) and Clinical Programs. Goals and objectives have been developed for each position.

The performance and quality improvement function has been separated from the regulatory function to allow more focus on each. An Interim Director for Quality Management/Performance Improvement is in place. Both functions report to the new Interim Associate Director of UM and Clinical Programs. Medical Staff and Graduate Medical Education (GME) personnel have agreed on proctoring protocols and resident supervisory process. All medical administrative documents have been updated and approved at Medical Executive Committee (MEC) level. Bylaws and rules and regulations have been updated and are now compliant with CMS and JCAHO regulations and standards.

A complete reorganization of the Care Management Department has been completed integrating social work, case management and bed management functions. Multidisciplinary Care Coordination Rounds have been instituted on units to discus the patient's plan of care and any issues that may impact their length of stay or transition to a lower level of care. Bed flow for medical/surgical

beds has improved, but the need for critical care and stepdown beds continues to create a significant bottleneck in both the ED and the PAR. Work to identify strategies to improve patient flow is actively underway. Admission criteria for critical care units have been drafted to improve and streamline the communication necessary to place a critical care patient. Recruitment for Patient Placement Coordinator continues.

Human Resources

The performance evaluation and management process has been revised with focused efforts with management to complete performance reviews. The percentage of completed performance evaluation has improved from 8% to 53%. A needs assessment has been completed with management and an educational plan is being developed to prioritize and address those needs. The process to receive HR advice, consultation, and coaching to management has been improved. HR involvement is earlier in the process with ongoing feedback and coaching to the manager to more effectively and efficiently resolve performance management and discipline issues. A process to more aggressively manage workmen's compensation issues has been developed for implementation. Efforts have been implemented to improve the recruiting process and priority needs have been identified.

Ancillary Services

A Laboratory Advisory Committee has been formed made up of physicians and laboratory staff. Issues being addressed include: Point of Care Testing; activation of IT functionality to support laboratory services; re-mapping of lab test menus; and preparations for the formation of a core lab operation within KDMC. The tracking and monitoring of all lab orders for future lab work (known as 'planned orders') is now in place which allows patients to receive written instructions to prepare for future lab work. At the same time, it enables bar-code label printing eliminating the need for double labeling of specimens. The laboratory re-designed the collection process for collecting blood culture samples and decreased contamination rates from 8.1% to 4%. A new process was implemented so patients no longer need to carry their blood specimens to the laboratory. A process was implemented by which outpatient clinics are able to order STAT lab requests. In the past, the service wasn't easily accessible unless a nurse was assigned to carry specimens to the lab department. Eight new patient instructions/handouts for lab tests requiring special preparation were developed, including Spanish translation. Phlebotomy services to collect specimens for

blood product transfusion were implemented which is expected to reduce the number of specimen rejections. STAT test ordering criteria have been adjusted to eliminate unnecessary use of STAT services. Revamping of the STAT test menu (in cooperation with the Lab Advisory Committee) is underway to focus efforts on clinically necessary STATs.

The College of American Pathologists (CAP) completed a two-day non-routine inspection of the laboratory department. The laboratory was highly commended for outstanding processes, excellent policies and procedures, and staff with sound clinical knowledge. Special mention was given to phlebotomy for having made improvements in the patient blood collection station; hematology for an outstanding staff competency program; and microbiology for sound policies and procedures in place, among other departments.

Radiology is working towards improved efficiency of operation by redistributing clinical responsibilities to supervisory personnel and identifying administrative functions that need to exist for improved departmental operation. They are exploring opportunities for cross training of technical personnel across radiographic modalities to better match staff to patient volume. The department has been working with the emergency department to evaluate transportation issues and establish transportation responsibilities as a result three additional personnel have been hired to provide interdepartmental transportation. The existing Picture Archival Communication System (PACS) has been upgraded for quality and ease of operation. A PACS team has been formed to address many issues relating to quality production of radiographic images, including optimal archival and gradual reduction of film usage, resulting in significant cost savings. A radiologist productivity tracking mechanism was implemented demonstrating that a few radiologists are reading a large number of examinations, while several other radiologists are providing a minimal amount of work. Through a group session with several Radiologists issues related to equitable distribution of workload are being addressed and productivity reports have been established and are being reviewed. A major problem in report production with an outside transcription service was identified and corrected. Several other problem areas were identified and improvements were made to enhance ease of dictation, faster report turnaround time for reports, and additional workstations for radiologist interpretations. Currently working with our radiologists we are attempting to establish a system whereby 90% of the procedures performed on any given shift are interpreted by the radiologist on that shift before he/she completes his/her shift. A teleradiology solution was

initiated to provide the facility with radiologist coverage on nights and weekends.

Health Information Management (HIM) has been working with the HUB Pediatric Clinic to begin the electronic progress note and to scan the records so that clinicians have immediate access. A trial is underway in the General Surgery clinic to trial a free form electronic progress note. After the workflow issues have been streamlined and workstations are in place for all clinics, the pilot will be rolled out to all the clinics. Criteria have been established for reviewing deficiencies in the quality and content of the medical record. Software has been ordered to improve tracking and create trend reports. Findings will be presented at grand rounds, appropriate committees and become a part of physician credential files. HIM has been working with File Keepers Record Storage vendor to log all charts into their chart tracking system. New software provided by them will allow KDMC to better locate the record at File Keepers. In November, there were several thousand radiology reports that could not be sent from the MedQuist software to Affinity. The reports were being rejected by Affinity due to a variety of errors on both the MedQuist and KDMC staff. We worked through the issues and eliminated the backlogged reports. Tracking is in place and turnaround time for reports has decreased from 30 hours to 10 by putting MedQuist on notice that we will get another vendor if they do not meet their contractual obligations. Efforts have been made to improve availability of outpatient medical records, delivery rates have increased from the mid 80s to 95%.
Efforts are underway to reduce turnaround times for inpatient and outpatient coding the goal being less than five days. A scheduling pilot in General Surgery clinic begins this month as an alternative to the current block scheduling.

In Pharmacy all registry staff have completed new employee orientation, and 80% of pharmacists have completed a competence assessment. Chapter 797 GAP analysis was completed and significant physical plant modifications will be needed. Planning for outpatient pharmacy relocation is underway. Work is underway with nursing to revise policies and procedures pertaining to medication administration. The outsourcing scope of services has been completed.

Environment of Care/Facilities/Space and Equipment

All occupied and vacant space has been physically inventoried. The newly configured Space Committee is prioritizing new space requests. Navigant

Consulting is evaluating current space and how it may better support operations as well as assisting in the prioritization of changes to meet regulatory requirements. Four critical space/construction needs have been identified: OP Pharmacy, OR, ER, and Psych.

Development of renovation plans is underway in the operating room and psychiatry. OSHPD has given preliminary approval to proceed with the OR, cost estimates are being completed. The Field Assessment Report for the psychiatric areas in Hawkins has been reviewed and all are in agreement as to the priority items that present safety hazards in the rooms. The ER is in initial stages of evaluation. An initial cost estimate breakdown of the refurbishment items has been made.

An inventory of all equipment is being completed including the tagging and bar coding all items. A decision will be made on a program to use to track equipment to better manage replacement and maintenance by tracking location, age, useful life, repairs etc.

Overall Work plan Progress

Of the 1,067 total recommendations 227 of them were considered urgent, 82% of those were completed. There have been 1280 action steps due to date (out of a total of 3,666) of which 85% have been completed. Of the total recommendations 284 or 27% have been completed.

There are thirty-eight Urgent items that remain Yellow. (The definition of Yellow being "completion is likely, however it may be delayed (not major delay. The issues are manageable.") Key issues impeding completion of these recommendations are:

- Dependency on the timeframes of the Hospital Advisory Board creation
- Limited recruitment results
- Technology implementation timetables controlled at the county level – OLR, Pharmacy GE PIS, ORSOS 10.x, MAR
- Competing space and facility priorities

There are two recommendations with a Red status (the definition of red being "Major risk has been identified, and/or completion will be delayed (major delay)"). The first involves recruitment in Materials and the second involves the timing of the installation of GE Pharmacy Information System.